MEDICAL AND LEGAL ASPECTS OF STERILIZATION IN INDIANA*

By L. POTTER HARSHMAN, *Psychiatrist*

Fort Wayne State School, Ft. Wayne, Indiana.

It is not the purpose of this paper to discuss the alleged rapid degeneration of the race or the expected effectiveness of sterilization of the feebleminded in a social and economic program. Neither is the paper an indictment of those who do not agree with Hitler's program covering nine different classes of individuals for sterilization. It is desired to report the workings of a recent law which we have enacted in Indiana and also we wish to present short discussion of the surgical phase of the problem.

In 1905 at the Vineland meeting of the Association of Medical Officers of American Institutions for Feebleminded Risley[1] of Philadelphia presented a paper on the subject of Asexualization of the Imbeciles. He stated, "To meet these problems wisely will require the united and best endeavor of the physician and the jurist and the wisest exercise of a broad and scientific philanthropy."

County and State Medical Associations in reality have a great deal to do with the average layman's idea of various problems of a medical or semi-medical nature. The habit of the average person to go to his family doctor for information has lead us to try to study the attitude of the medical profession toward sterilization in our state. Likewise this statute has given us an opportunity to ascertain the attitude of several judges in various parts of the Commonwealth. By letter we have inquired of various State Medical Associations as to what action had been taken in respect to their interest in the

1. Risley, S. D., Is Asexualization Ever Justifiable in the Case of Imbecile Children. Jr. Psycho-Aesthenics, 9:92-98, June, '05.

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subject. The following table where "yes" indicates official action, shows that we heard from forty-two of the forty-eight State Associations. It is obvious that little has been done by many of these societies, yet in those states not having any laws there is more action. Some of these societies in states having laws governing the problem have taken action supporting the laws after the laws were passed, or supporting a greater extension of the laws already in existence.

TABLE I.

		STATUTE			NO STATUTE	
		Medical Society			Medical Society	
		Yes	No		Yes	No
No Ans.	3	—	—	3	—	—
Ans.	24	8	16	18	10	8

In 1928 the matter was before the House of Delegates of the American Medical Association but no action was taken. The Medical Association of Hawaii has been active in promoting legislation of this kind, but so far has had no results.

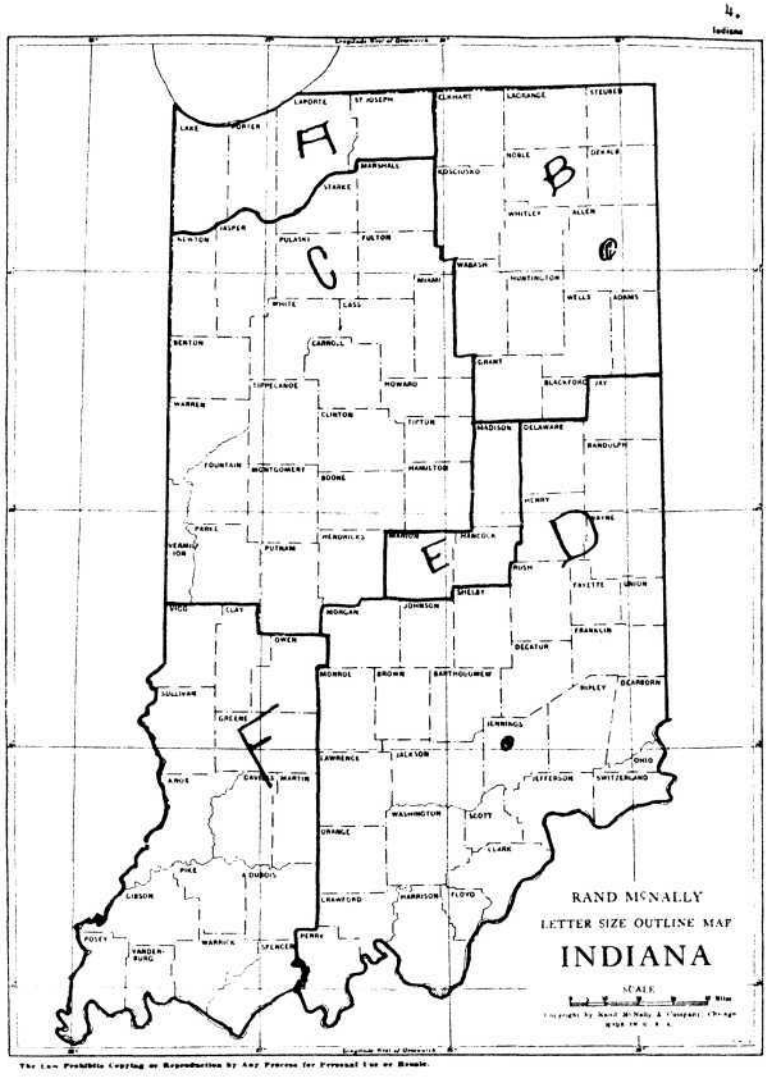
Before going further it is important to describe the geography and the population under which we exist in Indiana. So often we listen to long treatises without appreciating the longitude and latitude of the region of activity as well as the habits of the people living therein. Indiana is a State of a little over three million population growing at the rate of about one percent per year. For convenience the state has been divided into six sections, representing about a half million people in each district. District "A" represents the Calumet district with the steel mills and the Studebaker Automobile Industry. The large percentage of foreign population and the more or less recent development of these one time swampy districts are points of social importance. Section "B" has a variety of farm land, none of it too good, with several diversified factories among which might be mentioned those making musical instruments at Elkhart, automobiles at Auburn, and electrical devices of all sorts at Fort Wayne where the General Electric Refrigerators are made as well as the International

Harvester Trucks. In this section "B" also are numerous lake resorts. The southern portion of this is somewhat of a beet growing district. Section "C" is quite rural in its entire make-up and much of it takes on the aspect of the prairies. Purdue University, the State Agricultural College is located in the center of this district. Many years ago considerable natural gas was found in this part of the state and many factories and foundries started up but are now more or less extinct. America's first car, the Haines, was built in Howard County. The upper part of Section "D" is partly good agriculture and partly manufacturing with the Ball Mason Jar plants in Delaware County, but the most of the section in the south represents much rough land with lots of stone. Small unproductive farms have made this part of the state somewhat of a problem during the economic crisis. Of course French Lick is located here and is outstanding in that that is one place in the United States that is said never to have heard of Prohibition. The Bedford Lime Stone district is in this section and has been productive. Section "F" represents the coal mining district which has suffered much since 1931. Sections "D" and "F" have a decided southern atmosphere. Section "E" contains the Capitol City with numerous industries as well as good surrounding farm lands.

In the northern part of the state we have the Fort Wayne State School with a daily average attendance of 1680 feebleminded persons of six years and over. In Jennings county some two hundred miles southward we are developing a newer institution where we have 600 adult feebleminded of both sexes. Both institutions operate jointly at this time.

The history of Indiana's efforts in legalizing Human Sterilization is known to most people. Although the Hoosiers probably were not true pioneers, a few points of interest might be repeated. It was late in the '90's that Dr. Harry C. Sharp with the consent of the patients, deliberately, but without legal authority, sterilized a large number of male convicts at the state reformatory. At this time, he is credited with having devised the simple surgical procedure of Vasectomy for such operations. Although Michigan and Pennsylvania had

TABLE II.



tried to get laws passed, it was Indiana's lot to pass the first Sterilization Act in 1907. In 1920 and 1921 a long drawn out court case caused this act to be declared unconstitutional because of its opposition to the 14th Amendment of the United States Constitution. In 1925 a group of ambitious inhabitants prepared a proposed law which would cause all of the "Socially Inadequate" to be sterilized. This was so expansive that it did not get out of the hands of the Agricultural Committee where it is alleged to have been referred. In 1927 a law very similar to the Virginia law was enacted and is still in force for those cases of mental disorder being housed in tax supported institutions. After hearing Watkins'[2] splendid paper on Selective Sterilization at the Washington meeting of this organization in 1930, we were stimulated to action and later were in position to get some modifications in our legal machinery covering the subject. It was decided to leave the 1927 law intact and attempt to get a "Selective Sterilization" act through which would cause the sterilization hearing to be held in the chambers of the court in the home county at the time and place where the child was being committed to one of our schools for feebleminded. Finally we were constrained to consider only the primary type of mental defect in our proposed law; probably this was because in the rural districts they do know what heredity is and the proposed legislation received ample support of all committees as well as the Governor, and, the dissenting votes in the General Assembly were negligible. The operation of the law is simple. In every proposed commitment coming before the Judge of any Judicial District in the State, two examining physicians appointed by the court are to certify not only as to the feeblemindedness of the applicant but also as to whether or not in their opinion the patient is cacogenic and capable of reproducing offspring likewise afflicted. In view of the findings of the examining physicians, and, in view of the other facts obtained by the court, the Judge must find whether or not the best interests of the patient

2. Watkins, H. M., Selective Sterilization, Proc. Annual Session (54th) American Assoc. for Study of Feebleminded, May, 1930.

and Society will be benefitted by the sterilization of the applicant. At the same time the Judge does or does not authorize the operation to be done at the institution, not earlier than thirty days after admission. The operation as authorized is not mandatory on the part of the superintendent of the school. It is to be emphasized that this law does not include the insane, epileptic, or criminal types. It applies only to the feebleminded.

On the basis of the commitments under this act which will be referred to as the Acts of 1931, 465 patients have been studied at our two institutions. Eighty-nine Judges and 447 different Physicians have been involved in the proceedings. The Judges have seen from 1 to 36 different patients each and no one Doctor has seen more than 25 applicants.

Before making a comparison of the attitudes of the Judges and Doctors in these cases it is necessary to show on what basis we considered those eligible for sterilization. In the report of Watkins'[2] already referred to it has always been our impression that the criterion set down for the selection of cases was very good and was adopted by this association. By necessity in some instances and by choice in others we have varied from the program suggested. A comparison of the component parts of the two criteria is listed below, the first column showing those adopted by the American Association for the Study of the Feebleminded. The other column shows the criteria adopted by our Fort Wayne State School and Muscatatuck Colony. In discussing the variations it will be noted as stated before, only the primary types could be considered for operation under our law. We have doubted for various reasons the advisability of having a central Eugenics Board in Indiana. We feel that staff members in the institutions will make better decisions where there has been at least a thirty-day observation of the case. Many of our cases are observed over several months before a decision is reached. It may be quite desirable to wait until the patients have been fully trained, reached their I.Q. prediction and are ready to go out on parole. But a review of the releases and discharges as well as the escapes from the ordinary school for feebleminded makes us believe that many cases can have the operation done as a routine on admission and then when unexpected releases take place or furloughs are granted it is not necessary to abide the time of operation. This makes for a more flexible movement of population. Perhaps this convenient arrangement has the proportions of being a little too wholesale in the minds of most of you. What we are doing now may not be the thing we will do a few years from now, yet there is no dogmatism about our attitude. The enthusiasm for more home care of the defectives makes us feel we are progressive. It is not at all impossible to have on the medical staff men capable of doing the simple operations described. The division of responsibility might be desirable in some instances.

TABLE III

A. A. for S. F. M.	F. W. S. S.-M. C.
In Institution	In Institution
Secondary or Primary	Primary
Selected-Special Staff	Institution Staff
Fully Trained	Capable
I. Q. Prediction Reached	Stable
Suitable for Parole	For Labor
	To Family
	Delinquent
	Escapes
Operation by Outsider	Staff

The case load has been divided into four distinct age groups of which 158 were males 6 to 15 years of age inclusive, 92 were males over 16 years of age, 128 were females from 6 to 15 years inclusive, and, 87 were females over 16 years of age. These age groups will be discussed with reference to whether or not the Judge authorized sterilization. On the basis of the premises under which we have operated we have compared the Judge's findings with those we have made ourselves. In other words we have agreed with the Judge in some cases; we have had other cases over which there is still some debate;

and, there are other cases about whom we have disagreed with the Judges' findings.

A few words of explanation of the analysis of some of these groups presented in the following tables is in order. At the time this report was made a few of these patients were not yet operated for minor reasons, mainly we had not had time to do it. There are some in whom one could not determine whether or not the patient was of the primary type of mental defect even though they may have had a mental level either suitable or unsuitable for sterilization. Likewise some few were in very poor physical condition from chronic illness. Several of the primary type were decidedly too low to be given any other consideration than custodial. Of special interest in these groups are those in the tables designated by the asterisk. They are sufficiently high in mental level to be probable potential parents. Finally, in those high grade primary types we have an appreciable number wherein sterilization was not authorized, yet we felt it should have been. There is nothing which prevents us from taking care of these cases under the sterilization Acts of 1927 already mentioned.

The desire of the Doctors to vote in favor of sterilizing practically all of the group including idiots kept us from making any further tabulations as to Doctors' findings. The last columns show these attitudes, "yes" indicating that in their opinion the patient was cacogenic and a probable potential parent.

TABLE IV

AUTHORIZATION GIVEN Males

			6-15 Drs. Yes	6-15 years Drs. No
Agreed	53	Operated	99	3
		Not Operated	4	0
Debatable	14	Borderline	2	0
		? Type-Suit. M. L.	2	0
		? Type-Unsuit. M. L.	24	0
Disagreed	41	Poor Physical	2	0
		Prim. Unsuit. M. L.	44	0
		Sec. Unsuit. M. L.	34	0
		Sec. Suit, M. L.*		

TABLE V

NO AUTHORIZATION Males

			6-15 Drs. Yes	6-15 years Drs. No
Agreed	26	Poor Physical	0	0
		Prim. Unsuit, M. L.	35	7
		Sec. Unsuit. M. L.	6	2
		Sec. Suit. M. L.*	2	0
Debatable	15	Borderline	0	0
		? Type-Suit. M. L.	8	0
		? Type-Unsuit. M. L.	18	4
Disagreed	9	Suit, for Ster.	18	0

TABLE VI

AUTHORIZATION GIVEN Males

			Over 16 Drs. Yes	Over 16 years Drs. No
Agreed	30	Operated	44	2
		Not Operated	12	2
Debatable	6	Borderline	2	0
		? Type-Suit. M. L.*	8	2
		? Type-Unsuit. M. L.	0	0
Disagreed	16	Poor Physical	0	0
		Prim. Unsuit. M. L.	24	0
		Sec. Unsuit. M. L.	7	1
		Sec. Suit. M. L.*	0	0

TABLE VII

NO AUTHORIZATION Males

			Over 16 Drs. Yes	Over 16 years Drs. No
Agreed	27	Poor Physical	5	I
		Prim. Unsuit. M. 1.	20	4
		Sec. Unsuit. M. L.	4	6
		Sec. Suit. M. L.*	14	0
Debatable	0	Borderline	0	0
		? Type-Suit. M. L.	0	0
		? Type-Unsuit. M. L.	0	0
Disagreed	13	Suit, for Ster.	20	6

TABLE VIII

AUTHORIZATION GIVEN — Females

			6-15 years Drs. Yes	6-15 years Drs. No
Agreed	48	Operated	37	72	2
		Not Operated	11	22	0
Debatable	17	Borderline	1	2	0
		? Type-Suit. M. L.*	6	10	2
		? Type-Unsuit. M. L.	10	20	0
Disagreed	25	Poor Physical	1	2	0
		Prim. Unsuit. M. L.	15	30	0
		Sec. Unsuit. M. L.	4	7	1
		Sec. Suit. M. L.*	5	10	0

TABLE IX

NO AUTHORIZATION — Females

			6-15 years Drs. Yes	6-15 years Drs. No
Agreed	20	Poor Physical	0	0	0
		Prim. Unsuit. M. L.	9	14	4
		Sec. Unsuit. M. L.	8	14	2
		Sec. Suit. M. L.*	3	5	1
Debatable	6	Borderline	1	2	0
		? Type-Suit. M. L.*	1	2	0
		? Type-Unsuit. M. L.	4	8	0
Disagreed	12	Suit, for Ster.	12	24	0

TABLE X

AUTHORIZATION GIVEN — Females

			Over 16 years Drs. Yes	Over 16 years Drs. No
Agreed	37	Operated	30	58	2
		Not Operated	7	13	1
Debatable	6	Borderline	0	0	0
		? Type-Suit. M. L.*	5	8	2
		? Type-Unsuit. M. L.	1	2	0
Disagreed	21	Poor Physical	3	6	0
		Prim. Unsuit. M. L.	11	20	2
		Sec. Unsuit. M. L.	5	10	0
		Sec. Suit. M. L.*	2	4	0

TABLE XI

NO AUTHORIZATION — Females

			Over 16 years Drs. Yes	Over 16 years Drs. No
		Poor Physical	0	0	0
11 Prim. Unsuit. M. L.			7	12	2
Agreed	11	Sec. unsuit M.L.	2	4	0
		Sec. Unsuit. M. L.	2	4	0
		Sec. Suit. M. L.*	2	3	1
		Borderline	0	0	0
Debatable	3	? Type-Suit. M. L.*	2	4	0
		? Type-Unsuit. M. L.	1	0	2
Disagreed	9	Suit, for Ster.	9	18	0

A total of all of the cases for all ages is given in the two following tables and needs no further comment as some of the important details will be given in other tables.

TABLE XII

AUTHORIZATION GIVEN — All Sexes

			Over 6 years Drs. Yes	Over 6 years Drs. No
Agreed	168	Operated	141	273	9
		Not Operated	27	51	3
Debatable	43	Borderline	3	6	0
		? Type-Suit. M. L.*	17	28	6
		? Type-Unsuit. M. L.	23	46	0
Disagreed	103	Poor Physical	5	10	0
		Prim. Unsuit. M. L.	60	118	2
		Sec. Unsuit. M. L. 30, Sec. Suit. M. L.* 8	58 / 16	2 / 0

TABLE XIII

NO AUTHORIZATION — All Sexes

			Over 6 years Drs. Yes	Over 6 years Drs. No
Agreed	84	Poor Physical	3	5	1
		Prim. Unsuit. M. L.	49	81	17
		Sec. Unsuit. M. L.	19	28	10
		Sec. Suit. M. L.*	13	20	6
Debatable	24	Borderline	1	2	0
		? Type-Suit. M. L.*	7	14	0
		? Type-Unsuit. M. L.	16	26	6
Disagreed	43	Suit, for Ster.	43	80	6

To many it will appear that we have slated for surgery a rather high percentage of the patients. By noting the mental classification of the patients admitted it will be seen that only 25% of this group were idiots; that 33% were imbeciles, a large portion of which were high grade imbeciles, several of whom have had children and their commitments could be nothing else but the outcome of the economic crisis; and 41% of the group were morons.

TABLE XIV

	Bd.	M.	Imb.	Id.	Total	
Males	0	38	13	2	53	Sterilization
(6-15)	2	14	37	52	105	No "
Males	0	20	10	0	30	Sterilization
(Over 16)	1	24	20	17	62	No "
Females	0	36	12	0	48	Sterilization
(6-15)	1	19	30	30	80	No "
Females	C	27	10	0	37	Sterilization
(Over 16)	0	12	23	15	50	No "
Total	4	190	155	116	465	
% Appx.	1	41	33	25	100	

Of the 465 patients studied we listed for operation 168, or 36.1%. That is these were primary in type, and sufficiently high grade, and furthermore the authority had been granted. There were 43 or 9.2% in this group of sufficient mental level and primary but authority for operation was not granted. Twenty-one or 4.5% patients were definitely secondary types, but had a mental level suitable for sterilization.

The debatable group had 24 or 5% in it who were sufficiently high for surgery. In all then, according to the standard or scale set up at the beginning, we would like to have considered 256 or 55% of the total admissions for surgery whereas in reality we could consider 36.1%.

TABLE XV

Sexes	Males		Females		
Ages	6-15	16	6-15	16	Total
Total	158	92	128	87	465
Primary-Suitable M. L. for Sterilization					
Authorized	53	30	48	37	168
Not Authorized	9	13	12	9	43
Secondary-Suitable M. L. for Sterilization					
Authorized	1	0	5	2	8
Not Authorized	1	7	3	2	13

TABLE XVI

Debatable as to Type-Suitable M. L. for Sterilization

Sexes	Males		Females		
Ages	6-15	16	6-15	16	Total
Authorized	1	5	6	5	17
Not Authorized	4	0	1	2	7

As stated above further analysis of the Doctor's agreement or disagreement with the program would not lend any interesting information by comparing the figures. The table below does give an interesting phase of the stands taken by the Judges on whom the final responsibility rests. Nineteen Judges seeing from one to 33 patients each authorized every patient to be sterilized, yet at some time in these groups we had to disagree or debate the findings in one or more of the patients. Seven Judges seeing from 1 to 3 patients each authorized the operation in every case and we agree with their findings. Suffice it to say these comparative findings in the smaller groups have a great deal of chance occurrence. Fifteen Judges did not authorize a single case sterilized regardless of the patient, and these Judges saw 1 to 5 patients each. Thirteen more Judges authorized no sterilization in no instances and we did not debate nor question their findings. Thirty-four Judges tried to discriminate and make findings one way or the other, yet at some time or other we disagreed with their attempts. However, there was one Judge in the 89 who found that 2 cases should not be sterilized and that 7 should be and we agreed with him in each instance.

	Disagreed or Debatable	Agreement in full	Total
Authorized Every Pt.	**19 Judges (1-33)**	7 Judges (1-3)	***26***
Authorized No Pt.	**15 Judges (1-5)**	13 Judges (1-3)	**28**
Authorized Part of Pts.	**34 Judges (1-36)**	**1 Judge (9)**	**35**
Total	**68**	**21**	89

Referring again to the districted map of the state we have some impressions which we cannot give down as final, until the case load is considerably higher. The lowest percentage of authorizations by the Judges came from district "D", and the next lowest came from district "C".

In reviewing these findings of the Judges and the Doctors we are tempted to quote again from Risley's[1] article written 29 years ago, wherein he says, "Prejudice, praejudicium is a product of the subconscious mind, the fruitage of preconceived notions which, without the control afforded by induction from observed facts, reasons deductively and reaches conclusions based upon premises quite as liable to be erroneous as true." We are not discouraged, nor have we found out anything new. Yet we have the definite evidence that almost half of the Judges showed no bias one way or the other.

We do see that the two professions are entitled to more enlightenment on the subject and we believe that with a proper educational program sterilization in the community at large can be fostered. In view of these findings we have been cooperating with the Neuro-Psychiatric department of our one Medical School in the state and are covering the whole problem of Feeblemindedness by lectures with emphasis upon the place of sterilization as a panacea but not as a cure for all of the social ills. We are reaching some of the county medical societies and bar associations. Joint meetings between these two groups with sterilization as a subject makes an evening well spent. As soon as we reach the Senior Law students each

year at our State University Law School we will consider the initial attempts complete.

Since 1896 the literature is filled with numerous types of operations for the females. Kanter and Klowans[3] are enthusiastic about the approach by the vaginal route, especially in the multipara. Certainly this would lend to a shortened convalescence if one is not disturbed by the impression that a desirable antiseptic field is beyond question. At Iowa University Hospitals this method of approach is used a great deal with kinking, crushing, and ligation of the tubes after the Mandelener technique. Hofbauer buries the proximal end of the tube in a fold made by drawing the ovarian and round ligaments together. A purse string effect can be established by using portions of the broad ligament and it is claimed the tubes can be reunited at a later date if desired. Babington[5] buries the short proximal stump end of the bisected tube into the body of the uterus by a purse string invagination. Putney resects the cornu of the uterus and obliterates this with sutures and at the same time anchors the distal end of the tube against the ovarian ligament. Dickinson[7] objects to any method which causes too much folding of the broad ligament on the grounds that there is impairment of the ovarian circulation with undesired results.

We have followed many of Dickinson's[7] suggestions for the entire operation but have made some changes. We make a low transverse skin incision but instead of cutting the sheaths of the recti muscles we have sought to separate them in the mid line with a vertical incision. This incision in our hands

3. Kanter, A. E. & Klowans, A. H. Vaginal Sterilization, Am. Jr. Surg., 18:529-539, Dec, 1932.

4. Hofbauer, J., Utilization of Round Ligaments *in* Tuba! Sterilization S.G.O., 829-931, June, 1927.

5. Babington, S. H. Human Sexual Sterilization, Calif. & West. Mod. 6:24, Dec, 1928.

6. Putney, O. W. Sterilization Without Unsexing, Va. Med. Jr., 57:180-183, June, 1930.

7. Dickinson, R. L. & Bryant, L. S. Control of Conception, 131-13* 1931, Williams & Wilkins, Baltimore.

has always given a good approach to the tubes, but of course to nothing else in the abdomen. In operating the smaller girls we have encountered difficulties which have gradually lead us to a slightly different type of operation wherein we split the broad ligament, resect a portion of tube then bisect it rather close to the uterus, then with ligature and suture anchor the proximal end into the side wall of the uterus, the broad ligament collapsed, and the cut distal end shunted outward into the peritoneal cavity. This attention to the distal end, we believe, acts as an added safeguard to the possibilities of the restablishment of a channel through which ova or spermatozoa might migrate. Particularly is this true if for some reason the obliteration of the proximal end had been incomplete. Any of these operations except those resecting the cornu gives the possibilities later on of a very localized salpingitis or infection of the adnexa. It remains to be reported just how extensive and how frequently this might occur.

Anyone in attendance at a large Obstetrical Clinic cannot help but be impressed at the presence of women on whom sterilization operations had been done but not effectively. Surgeons with wide general experience can always relate experiences like this in their private practices. Conflicting reports appear in the literature as to the efficacy of certain operations. On the basis that any job worth doing is worth doing well we attempted to review the literature discussing the causes of failures of sterilizing operations. We could find very little consideration of the subject in the American literature. In the French literature Pakrowsky[8] has reviewed with clarity the facts as found in some organized clinics as well as those in detached hospitals. He concludes that we should really speak of sterilizations as "provisional" rather than sure. Histological experiments on animals tend to show that many of the easier ligating methods were not effective because of the atrophy of the muscular and submucous coats but not of the epithelial

8. Pakrowsky, *W.* A., Gynecologic, 31:363-373, June, 1932.

linings of the tubes. He also calls attention to the dangers of tubo-peritoneal fistulae and utero-peritoneal fistulae where resections of the tube and where cornu operations are not done with the greatest of care.

In August, 1931 we began to study the females sixty days after operation by what we chose to call uterographies, using the method of Jarcho in injecting iodized oil into the uterine cavity under pressure. In reviewing the literature we found that this particular use of the method of study had been referred to by Gill[9]. In discussing the failures of the Mandelener technique, Wolf[10] used this method in Germany on a very few cases. A warm solution of iodized oil is injected into the uterus and while it is maintained under a pressure of 160 mm a roentgenogram is taken to see if any leakage takes* place at the sight of operation on the tubes. So far one case has shown some extravasation of the oil into the broad ligament. Later we are expecting to have a case load of sufficient size and quality to give a more comprehensive report on this method as being a test as to the efficiency of the operation used. In the smaller girls this examination does not appear advisable.

In males a modified Steinach operation through one skin incision in the scrotum has been used through which both vas can be exposed. For the adults spinal anesthesia has been preferred as it is less painful and does not clutter up the operative field with the edema presented by local anesthesia. About one-third the dose for abdominal work is needed.

In conclusion we believe the state institutions can aid the medical and legal professions to a large measure by carrying on an educational program with these groups primarily; and, that sterilization at large will become a procedure applied not without foresight and indiscrimination but with exemplary precision.

9. Gill, J. R. Eugenic Sterilization, Va. Med. Jr., 58:382-384, Sept., 1931.

10. Wolf, H. W. Roentgenkontrol. Mandelener. Ster. u.d. sick ergeb Schlussfolg, Zentral. f. Gynakologie; 56:1381-1387, June 4, 1932.